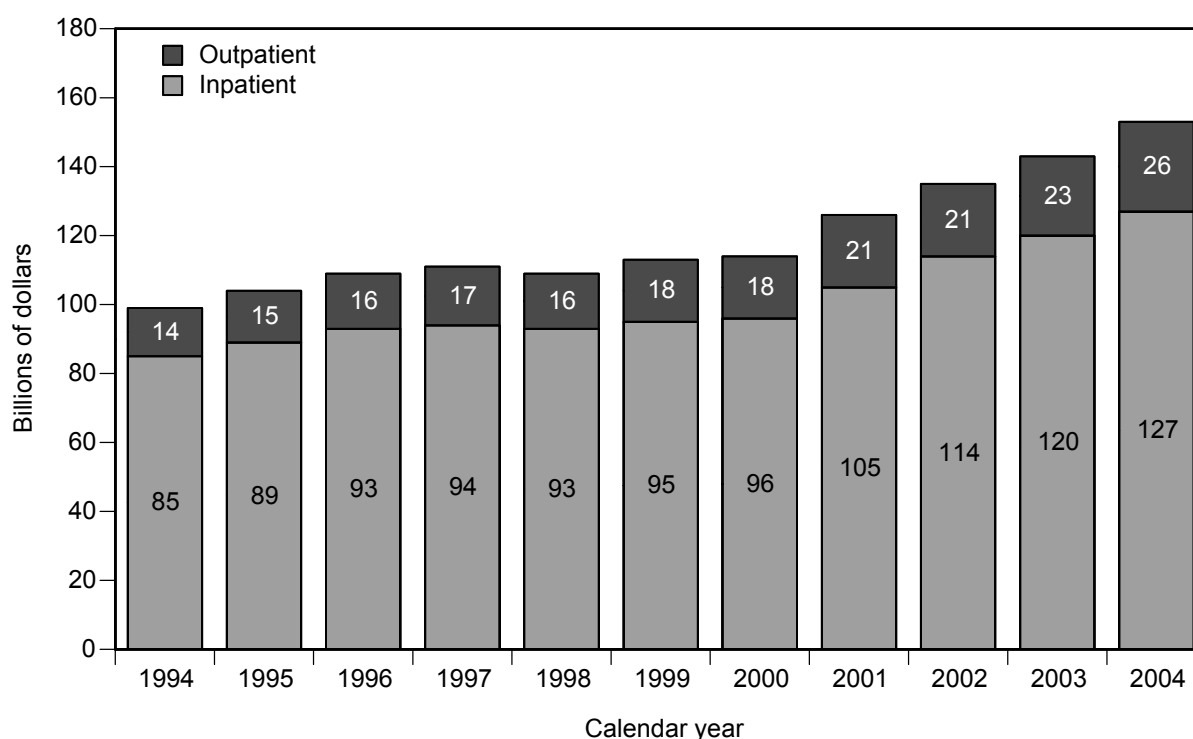


S E C T I O N

7

Acute inpatient services
Short-term hospitals
Specialty psychiatric facilities

Chart 7-1. Growth in Medicare's payments for hospital inpatient and outpatient services continues, 1994–2004



Notes: Analysis includes inpatient services covered by the acute inpatient prospective payment system (PPS); psychiatric, rehabilitation, long-term care, cancer, and children's hospitals and units; outpatient services covered by the outpatient PPS; and other outpatient services. Payments include both program outlays and cost sharing incurred by beneficiaries.

Source: CMS, Office of the Actuary.

- Medicare hospital inpatient spending increased 50 percent (4.1 percent per year) and outpatient spending 91 percent (6.7 percent per year) from 1994 to 2004.
- A freeze in inpatient payment rates in the Balanced Budget Act of 1997 (BBA), combined with lower Medicare discharges, reduced inpatient spending in 1998. Higher Medicare discharges, a higher update, case-mix change, and expansion of disproportionate share hospital payments increased inpatient spending in 2001 and 2002. In 2003 and 2004, slower Medicare discharge growth, slower case-mix change, and lower outlier spending led to slight moderation in inpatient spending growth.
- Outpatient spending fell in 1998, reflecting the BBA's elimination of inadvertent overpayments. Transitional corridor and new technology payments in the outpatient prospective payment system, along with volume increase, increased outpatient spending in 2001 and 2002. Slower volume growth and changes in pass-through payments led to slower expenditure growth in 2003. Payment for certain outpatient drugs on an average wholesale price basis increased payments in 2004.
- Aggregate Medicare inpatient spending was \$127 billion and outpatient spending was \$26 billion in 2004.

Chart 7-2. Diagnosis related groups with highest volume, fiscal year 2004

DRG number	DRG name	Percentage of discharges	Percentage of payments
127	Heart failure and shock	6%	4%
89	Simple pneumonia and pleurisy age >17 with CC	5	3
209	Major joint and limb reattachment procedures of lower extremity	4	5
88	Chronic obstructive pulmonary disease	3	2
182	Esophagitis, gastroenteritis, and miscellaneous digestive disorders age >17 with CC	2	1
174	GI hemorrhage with CC	2	1
296	Nutritional and miscellaneous metabolic disorders age >17 with CC	2	1
143	Chest pain	2	1
416	Septicemia age >17	2	2
14	Intracranial hemorrhage or stroke with infarct	2	2

Note: DRG (diagnosis related group), CC (complication or comorbidity), GI (gastrointestinal).

Source: MedPAC analysis of MedPAR data from CMS.

- In fiscal year 2004, 10 diagnosis related groups (DRGs) accounted for 30 percent of discharges and 21 percent of payments at hospitals paid under the acute inpatient prospective payment system.
- In fiscal year 2006, Medicare inpatient cases are assigned to 524 DRGs based on discharge diagnoses, procedures performed, age, sex, discharge destination, and presence of complications or comorbidities.

Chart 7-3. Number of acute care hospitals and Medicare discharges, by hospital group, 2004

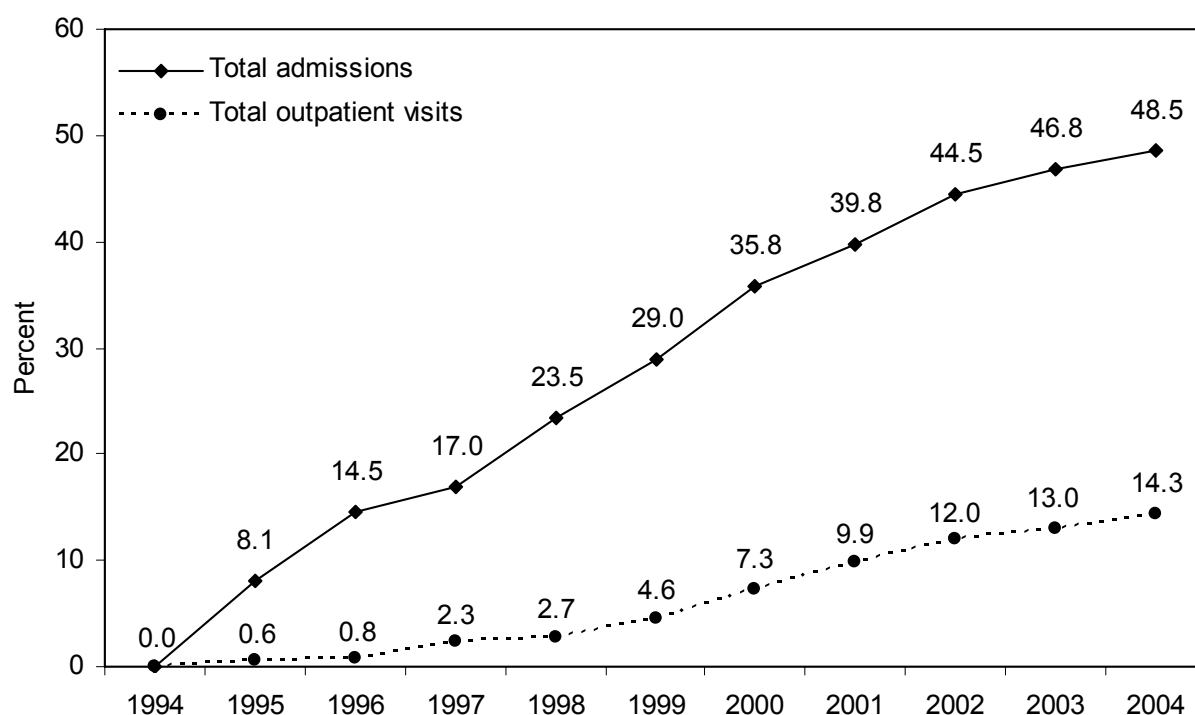
Hospital group	Hospitals		Medicare discharges	
	Number	Share of total	Number (thousands)	Share of total
All PPS and critical access hospitals	4,450	100.0%	12,741	100.0%
PPS hospitals	3,575	80.3	11,501	90.3
Urban	2,482	55.8	9,694	76.1
Rural	1,093	24.6	1,807	14.2
Large urban	1,373	30.9	5,288	41.5
Other urban	1,109	24.9	4,405	34.6
Rural referral	137	3.1	486	3.8
Sole community	450	10.1	707	5.5
Small rural Medicare-dependent	165	3.7	178	1.4
Other rural <50 beds	132	3.0	94	0.7
Other rural ≥50 beds	209	4.7	342	2.7
Voluntary	2,147	48.2	8,280	65.0
Proprietary	770	17.3	1,800	14.1
Government	652	14.7	1,418	11.1
Major teaching	297	6.7	1,734	13.6
Other teaching	783	17.6	3,980	31.2
Nonteaching	2,495	56.1	5,787	45.4
Critical access hospitals	875	19.7%	1,241	9.7%

Note: PPS (prospective payment system). Analysis includes all hospitals covered by Medicare's inpatient prospective payment system along with critical access hospitals. Maryland hospitals are excluded. Large urban areas have populations of more than 1 million. Major teaching hospitals are defined by a ratio of interns and residents to beds of at least .25. Other teaching hospitals have a ratio of below .25.

Source: MedPAC analysis of impact file and Medicare cost report data (August 2004) from CMS.

- In 2004, 3,575 hospitals provided 11.5 million discharges under Medicare's acute inpatient PPS and 875 critical access hospitals provided another 1.2 million discharges.
- About 17 percent of acute care hospitals (21 percent of PPS hospitals) are covered by special payment provisions intended to help rural facilities that do not become critical access hospitals (rural referral, sole community, and small rural Medicare-dependent hospitals); these facilities provide 11 percent of all discharges.
- See Chart 7-26 for more information about critical access hospitals.

Chart 7-4. Cumulative change in total admissions and total outpatient visits, 1994–2004

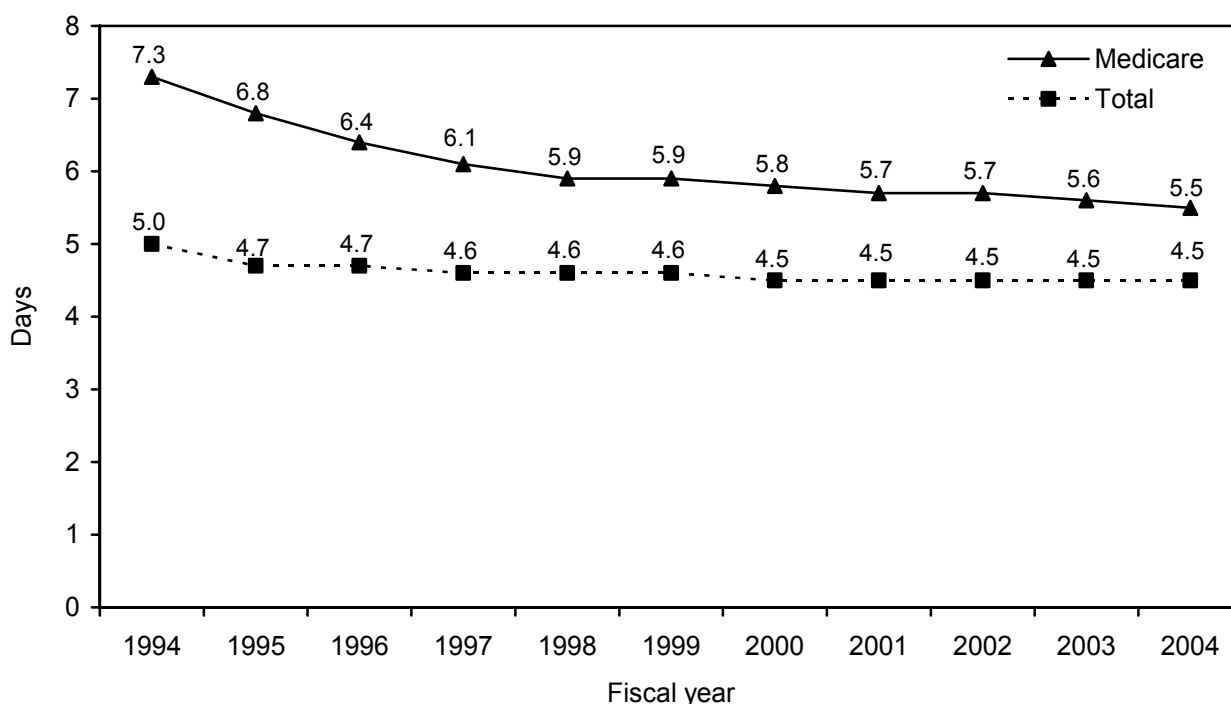


Note: Cumulative change is the total percent increase from 1994 through the year indicated. Data are admissions to and outpatient visits at approximately 5,000 community hospitals, excluding nursing home units.

Source: American Hospital Association Annual Survey of Hospitals.

- Hospital outpatient service use has grown much more rapidly than inpatient service use. Total hospital outpatient visits increased 49 percent from 1994 to 2004, while total admissions grew just 14 percent.
- There were 577 million outpatient visits and 35 million admissions to community hospitals in 2004.

Chart 7-5. Trends in Medicare and total hospital length of stay, 1994–2004

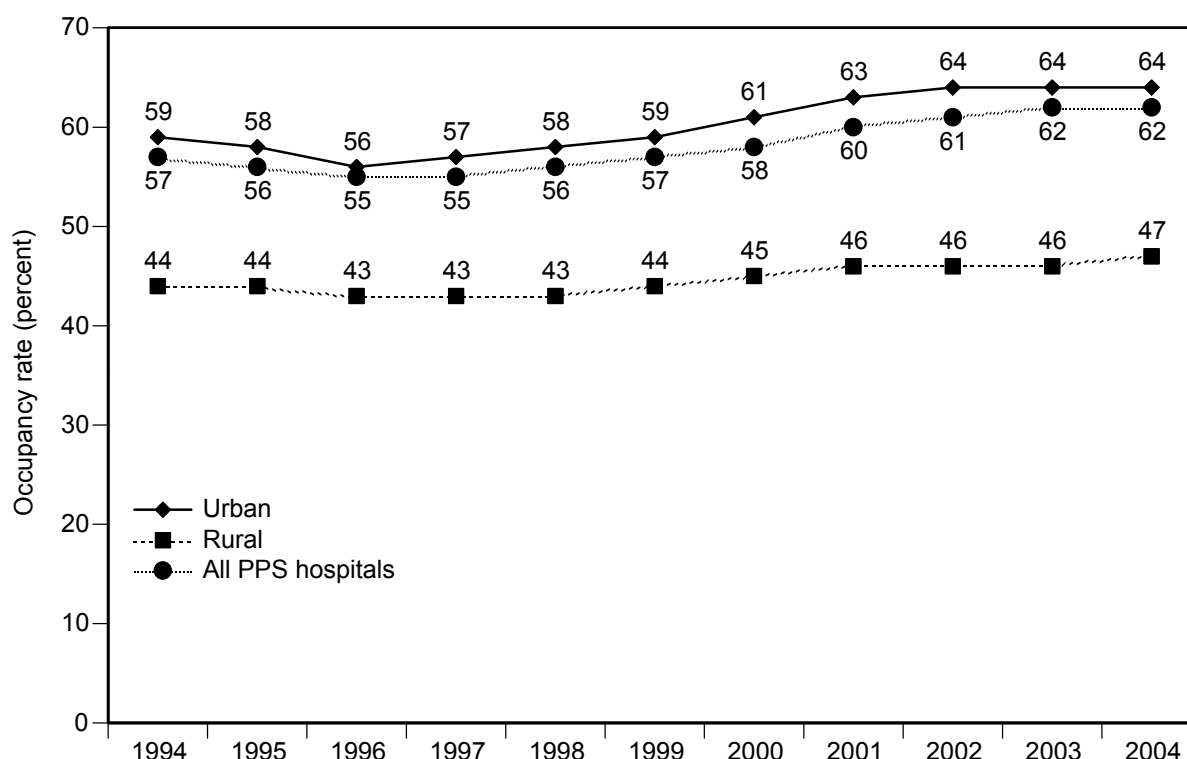


Note: Length of stay is calculated from discharges and patient days for approximately 3,600 hospitals covered by the acute inpatient prospective payment system. Excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Length of stay for all hospital discharges fell 11 percent from 5.0 days in 1994 to 4.5 days in 2004, dropping at an average annual rate of 2.6 percent from 1994 to 1997 and 0.6 percent from 1997 to 2004.
- Length of stay for Medicare inpatients fell 25 percent from 7.3 days in 1994 to 5.5 days in 2004, dropping at an average annual rate of 5.8 percent from 1994 to 1997 and 1.5 percent from 1997 to 2004.

Chart 7-6. Hospital occupancy rates, 1994–2004

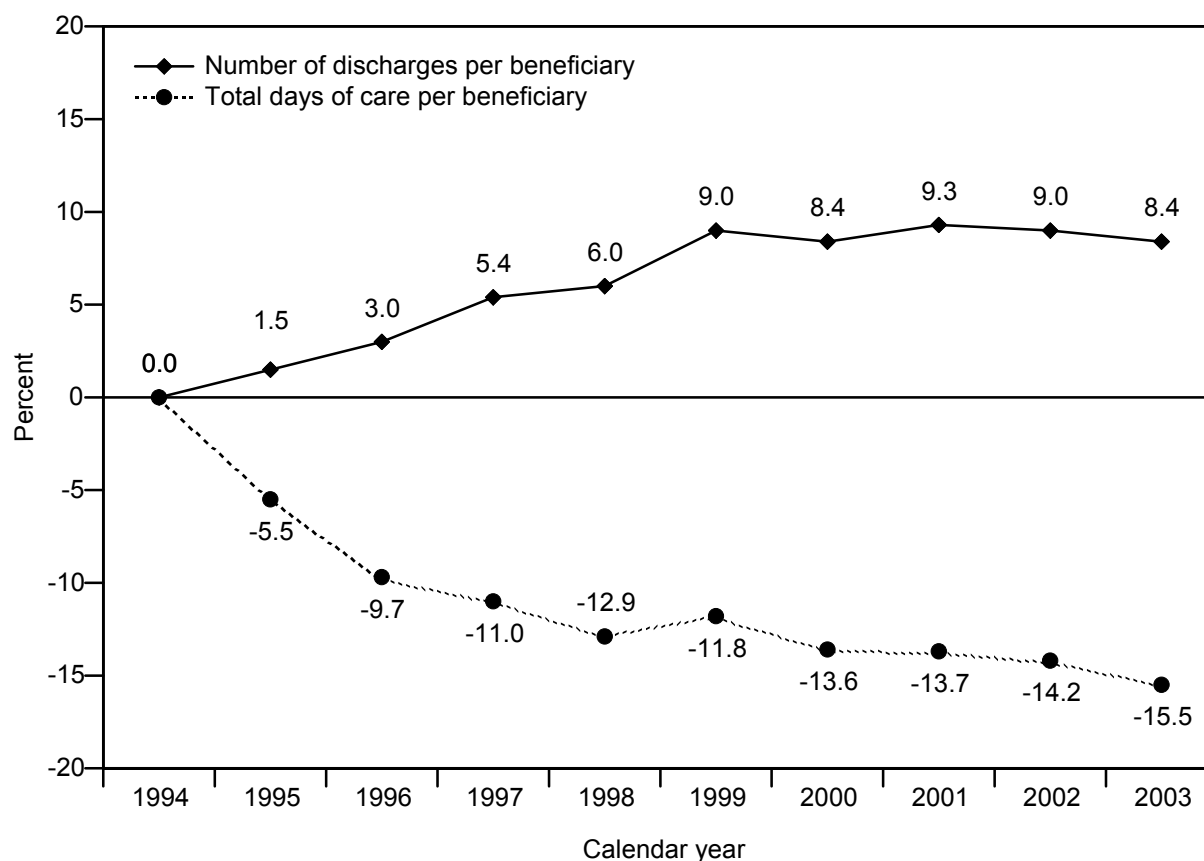


Note: PPS (prospective payment system). Hospital occupancy rate is measured as total inpatient days as a percent of total available bed days in the hospital over the cost reporting period. Theoretically, bed days available are staffed beds that are available for inpatient service (i.e., the units are open and operating), but the beds may not be staffed for a full patient load in that unit on any given day. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Hospitals' occupancy rates have been rising since 1996, with the aggregate occupancy rate climbing from 55 percent in 1996 to 62 percent in 2004.
- Occupancy rates in aggregate are much higher in urban than rural hospitals; in 2004, occupancy rates stood at 64 percent for urban hospitals and 47 percent for rural hospitals, a 17 percentage point difference. The occupancy rate in major teaching hospitals was 75 percent in 2004, the highest of all hospital groups.
- Since 1997, occupancy rates have gone up more for urban hospitals than rural hospitals, climbing 8 percentage points for urban hospitals and 4 percentage points for rural hospitals.
- Hospitals with lower occupancy rates (those in the bottom quartile) have lower Medicare and total (all payer) margins than hospitals in the top quartile of hospital occupancy rates. For example, in 2004, the aggregate overall Medicare margin for hospitals in the bottom quartile of occupancy was 7.0 percent lower than for hospitals in the top quartile.

Chart 7-7. Cumulative change in Medicare inpatient days per beneficiary and discharges per beneficiary, 1994–2003



Note: Cumulative change is the total percent increase from 1994 through the year indicated. Data are short-stay hospital Medicare patient days and discharges. Rate is per beneficiary enrolled in Part A. The statistics do not reflect managed care enrollment.

Source: MedPAC analysis of claims file and enrollment data from CMS.

- While discharges per beneficiary have increased, length of stay has fallen. Medicare hospital use rates increased from 1994 to 2003, with 8.4 percent more hospital discharges per enrollee at the end of the period. However, declining length of stay led to 15.5 percent fewer days of inpatient care for each enrollee in 2003 compared to 1994.
- There were 363 Medicare hospital discharges and 2,126 patient days per 1,000 beneficiaries enrolled in Part A in calendar year 2003.

Chart 7-8. Simulated Medicare inpatient payments, by component and hospital group, reflecting 2006 payment policy

Hospital group	Percent of total payments					Total payments (millions)
	Base	IME	DSH	Outlier	Additional rural hospital*	
All hospitals	81.5%	4.9%	7.7%	4.0%	1.9%	\$107,856
Urban	81.5	5.5	8.1	4.4	0.5	94,613
Rural	81.0	0.5	4.8	1.5	12.3	13,243
Large urban	79.9	6.7	8.7	4.7	0.1	53,955
Other urban	83.7	3.9	7.4	4.0	1.0	40,658
Rural referral	88.4	1.6	7.3	2.8	0.0	3,661
Sole community	70.3	0.2	2.0	0.7	26.9	6,005
Small rural Medicare-dependent	93.2	0.1	4.6	0.9	1.3	997
Other rural <50 beds	91.6	0.0	7.5	0.9	0.0	509
Other rural ≥50 beds	90.6	0.1	7.6	1.7	0.0	2,071
Voluntary	82.3	5.3	6.8	4.1	1.6	78,898
Proprietary	83.5	1.5	9.8	3.5	1.6	15,289
Government	74.2	6.3	10.9	4.5	4.1	13,642
Major teaching	67.3	16.2	10.5	5.9	0.1	23,818
Other teaching	83.9	3.6	7.6	3.9	1.0	38,278
Nonteaching	86.8	0.0	6.4	3.2	3.7	45,760

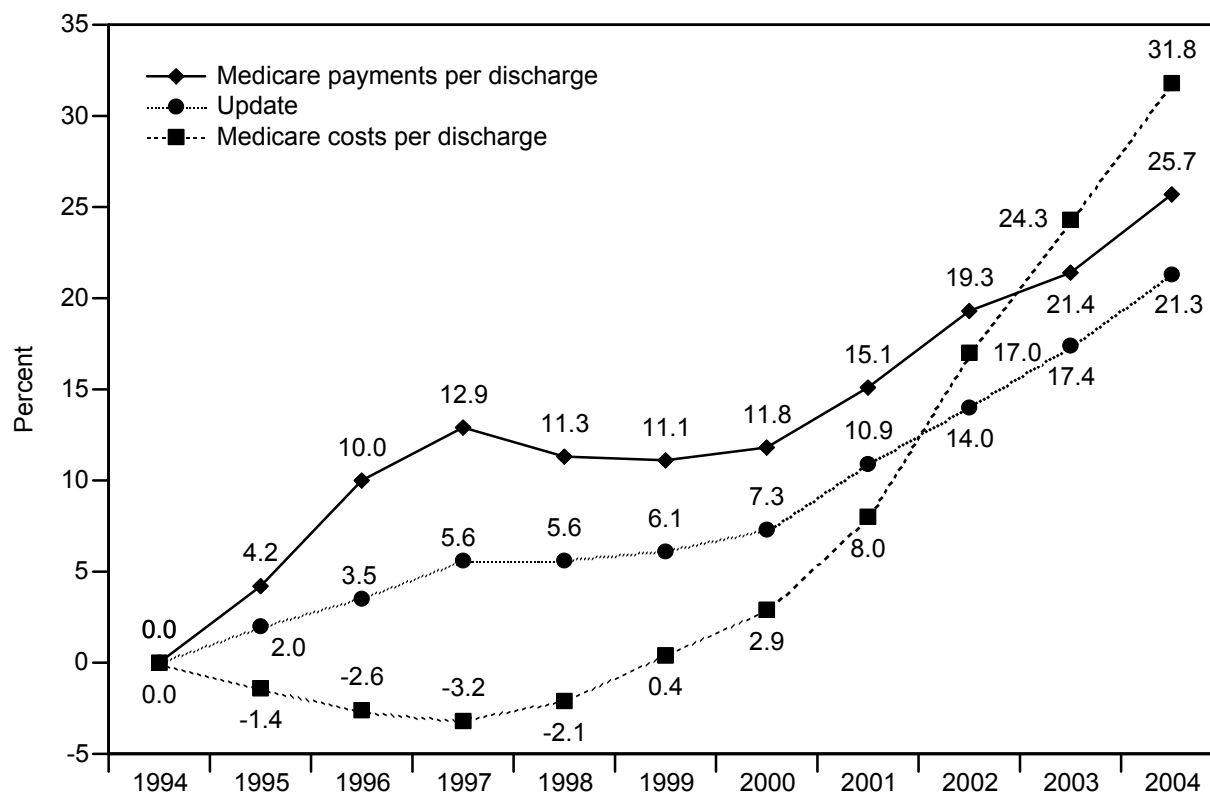
Note: IME (indirect medical education), DSH (disproportionate share). Analysis includes all hospitals covered by Medicare's acute inpatient prospective payment system (PPS). Includes both operating and capital payments but excludes graduate medical education (GME) payments. Simulated payments reflect 2006 payments rules applied to actual number of cases in 2004. Actual payments in 2006 will likely be higher than shown due to growth in number of cases.

*Payments received by sole community and Medicare-dependent hospitals beyond what would have been received under PPS. A few sole community hospitals are located in urban areas.

Source: MedPAC analysis of claims and impact file data from CMS.

- If the discharges that hospitals covered by the acute inpatient prospective payment system furnished in 2004 had been paid for under 2006 payment policies, then Medicare would have spent \$108 billion. This figure is less than actual Medicare spending on hospital care in 2006 because it does not reflect increases in admissions from 2004 to 2006 and because it excludes payments made to critical access, rehabilitation, psychiatric, and long-term care hospitals as well as hospitals in Maryland and the U.S. territories.
- Special payments—which include disproportionate share (DSH), indirect medical education (IME) and outlier payments, as well as additional payments to rural hospitals through the sole community and Medicare-dependent programs—account for 19 percent of all inpatient payments. This proportion is slightly lower for urban than rural hospitals, although urban hospitals get most of their assistance from DSH, IME, and outlier payments while rural programs account for most of rural facilities' extra funds. Major teaching hospitals have the largest share of payments coming from special payments, about 33 percent.

Chart 7-9. Cumulative change in Medicare acute inpatient PPS payments and costs per case, and operating update, 1994–2004

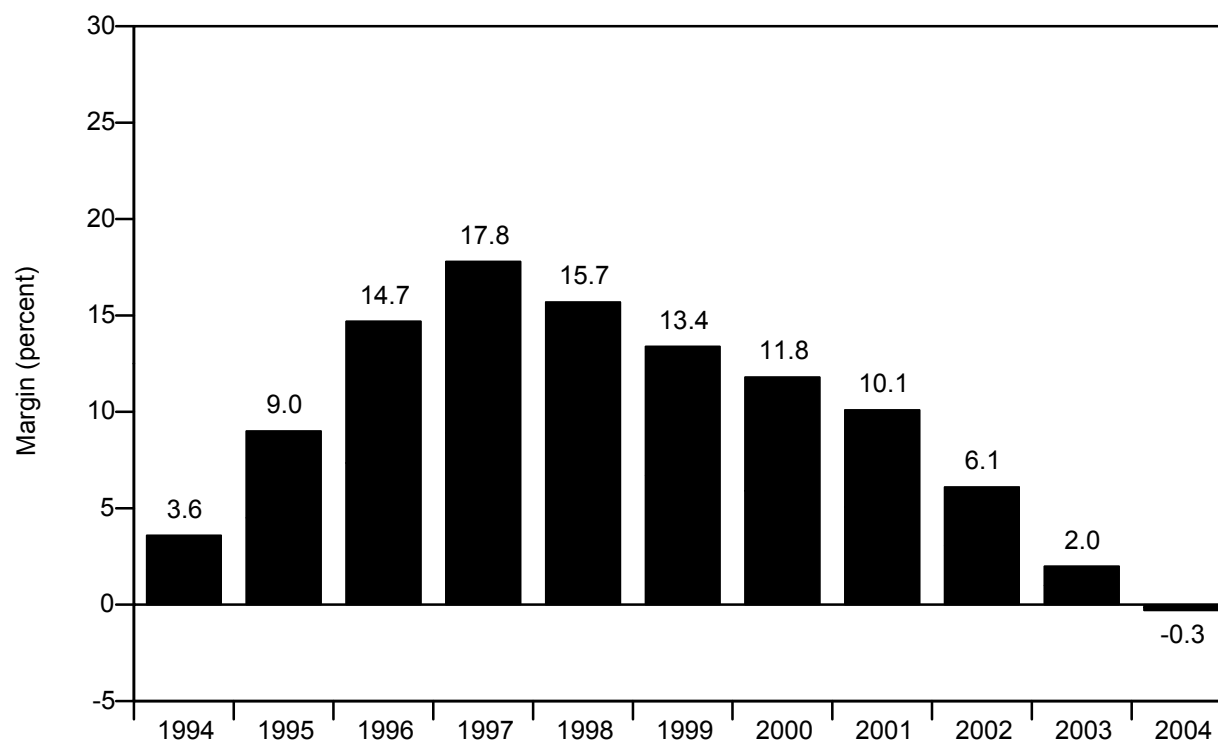


Note: PPS (prospective payment system). Analysis includes all hospitals covered by Medicare's acute inpatient PPS. Cumulative change is the total percent increase from 1994 to the year indicated.

Source: MedPAC analysis of Medicare cost report data and market basket data from CMS.

- From 1994 through 2002, cumulative growth in payments per case exceeded growth in costs per case. In recent years, however, hospitals' costs have increased much faster than the hospital market basket, due in part to the lack of financial pressure from private payers (see Chart 7-24).
- The cumulative update increased the inpatient operating payment rates 21.3 percent from 1994 to 2004, 10.5 percentage points less than the growth in hospitals' costs per discharge. However, hospitals' payment increases have exceeded the updates, due mostly to increases in case mix.

Chart 7-10. Medicare acute inpatient PPS margin, 1994–2004

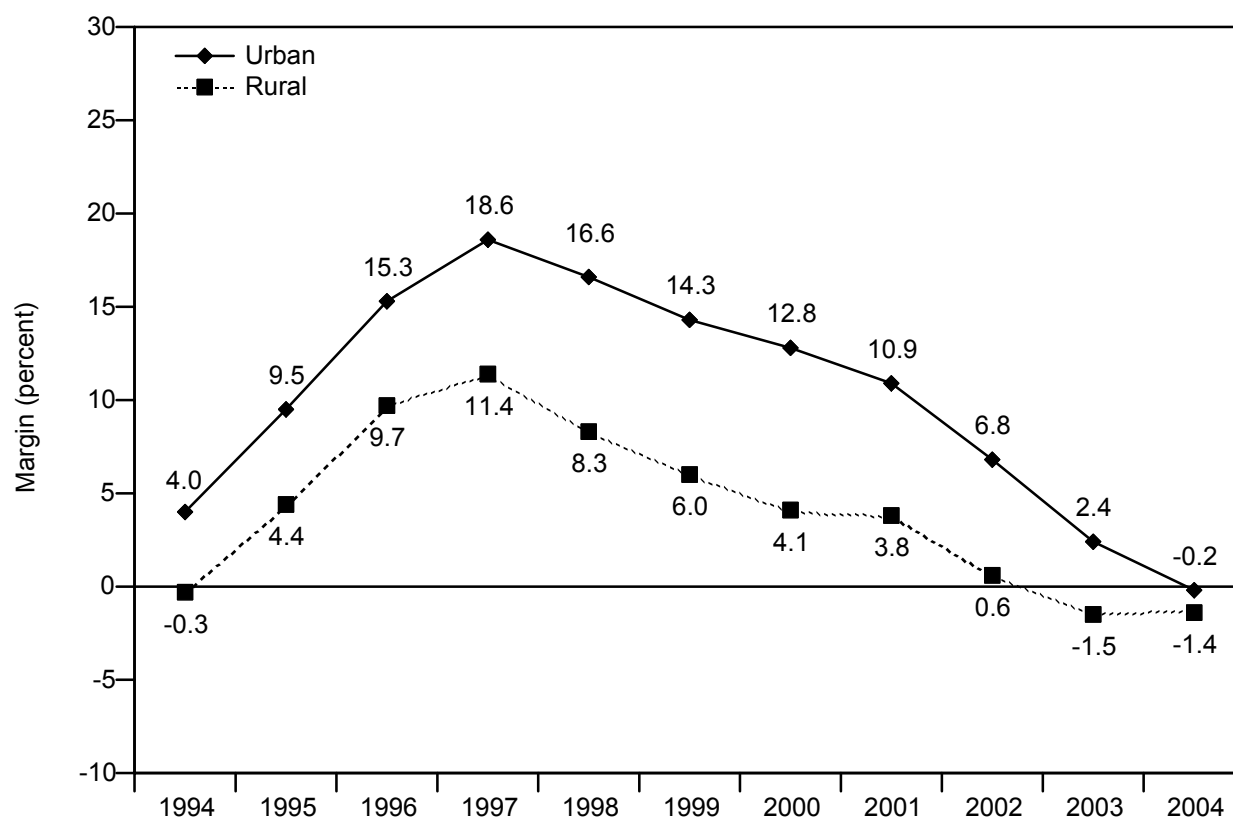


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Medicare's acute inpatient margin reflects payments and costs for services covered by Medicare's inpatient hospital prospective payment system (PPS). The inpatient margin may be influenced by how hospitals allocate overhead costs across service lines. Only by combining data for all major services can we estimate Medicare costs without the influence of how overhead costs are allocated.
- The Medicare inpatient margin increased steadily from 3.6 percent in 1994 to a record high of 17.8 percent in 1997. After implementation of the Balanced Budget Act of 1997, however, inpatient margins fell. In 2004, the margin was –0.3 percent, the lowest level since 1992.
- Medicare inpatient margins vary widely. In 2004, one quarter of hospitals had Medicare inpatient margins that were 10.0 percent or higher, and another quarter had margins that were –14.5 percent or lower. Between 1997 and 2003, this difference between the top and bottom quarter widened from 19 percent to 25 percent. About 47 percent of hospitals treating 41 percent of Medicare cases had positive inpatient Medicare margins in 2004.

Chart 7-11. Medicare acute inpatient PPS margins, by urban and rural location, 1994–2004

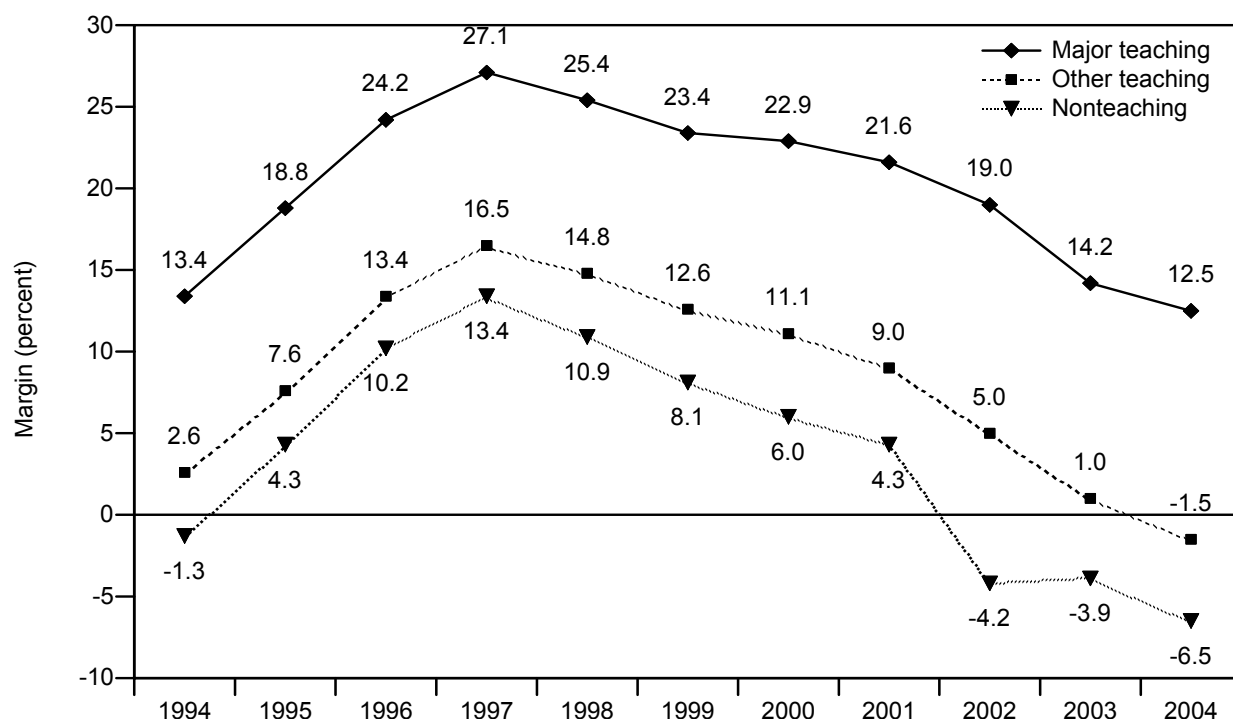


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Medicare inpatient margins have consistently been higher for urban hospitals than for rural hospitals. A large part of this difference in financial performance can be explained by disproportionate share and indirect medical education adjustments that go primarily to urban hospitals.
- The gap between urban and rural hospitals' inpatient margins grew between 1994 and 2000. One factor in this divergence is that urban hospitals had greater success in controlling cost growth, at least partly in response to pressures from managed care. From 2001 through 2004, this difference narrowed substantially, as payment policies targeted at raising rural hospital payments were implemented.

Chart 7-12. Medicare acute inpatient PPS margins, by teaching status, 1994–2004

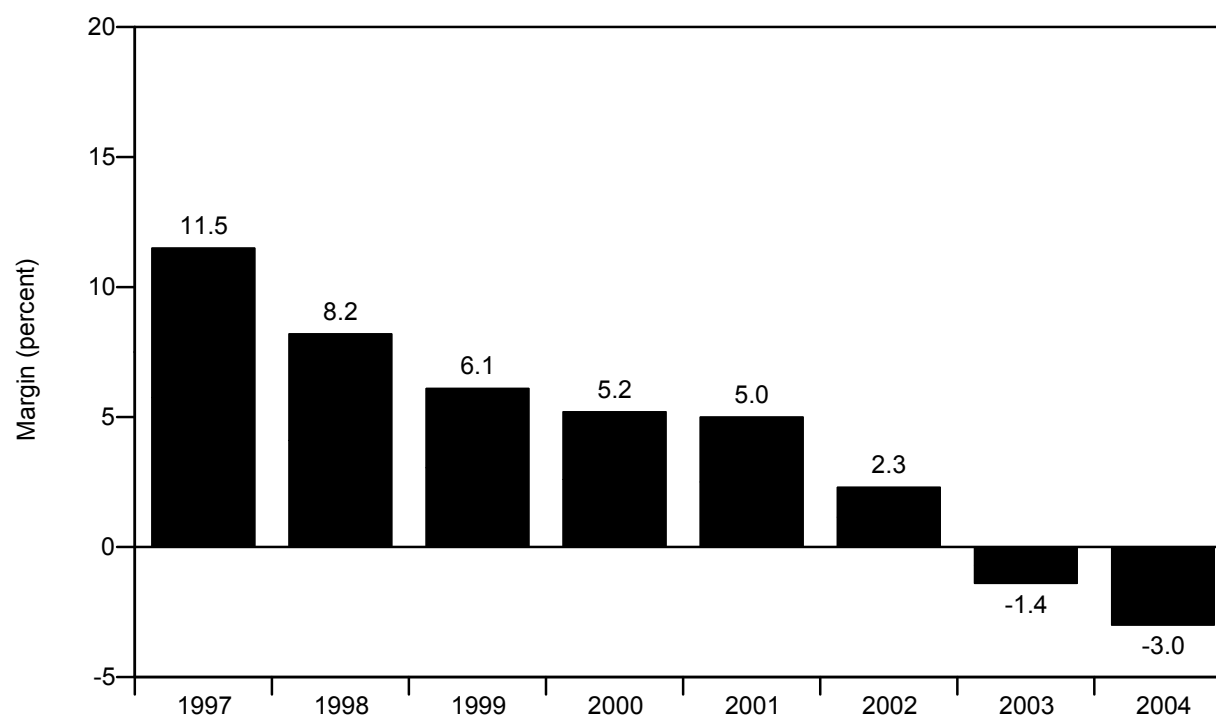


Note: PPS (prospective payment system). Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute inpatient PPS.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Major teaching hospitals have consistently had higher inpatient prospective payment system (PPS) margins than other teaching hospitals and nonteaching hospitals. Major and other teaching hospitals' better financial performance is due largely to the additional payments they receive from the indirect medical education and disproportionate share adjustments.
- Margins rose substantially for all groups through 1997, peaking at 27.1 percent for major teaching hospitals and 13.4 percent for nonteaching hospitals. Since then, inpatient margins have fallen less for major teaching hospitals than for nonteaching hospitals, dropping 14.6 and 19.9 percentage points, respectively, primarily reflecting lower growth in per case costs for major teaching hospitals.

Chart 7-13. Overall Medicare margin, 1997–2004

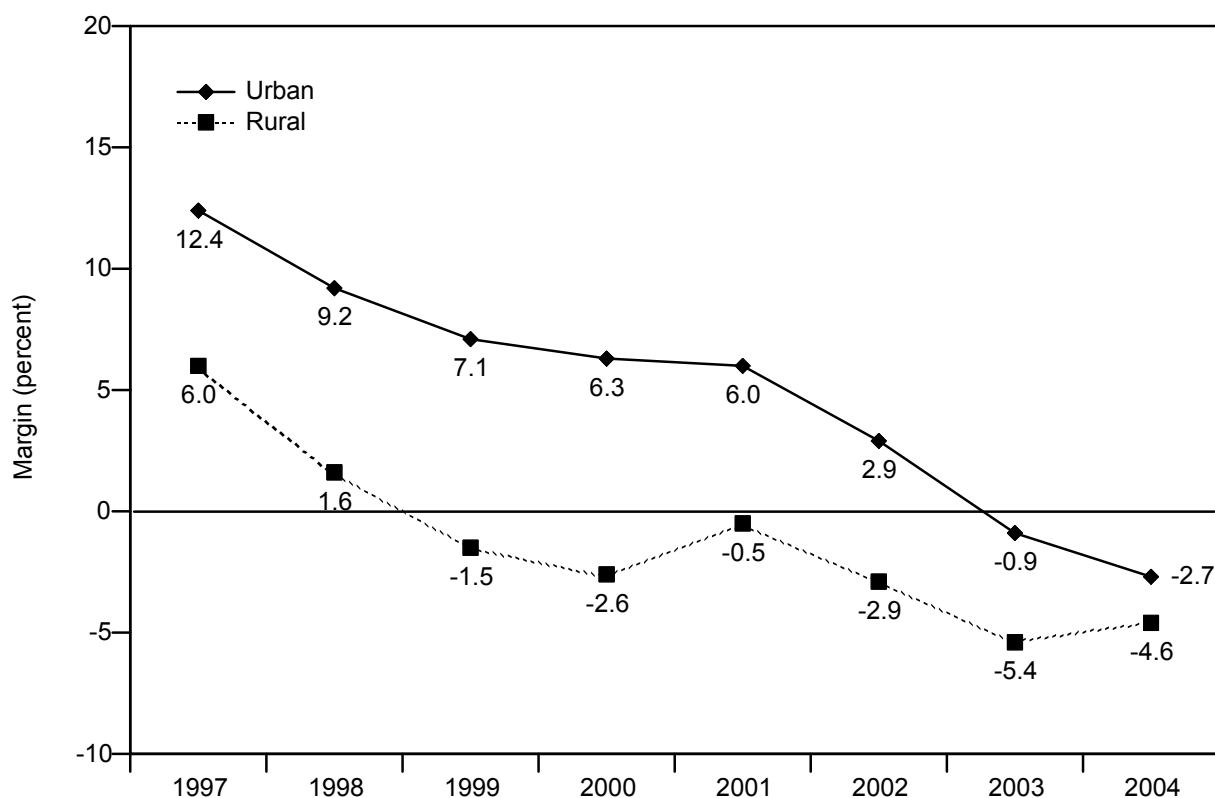


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- The overall Medicare margin incorporates payments and costs for acute inpatient, outpatient, skilled nursing, home health, and inpatient psychiatric and rehabilitative services, as well as graduate medical education and bad debts. The overall margin is available only since 1997, but it follows a trend similar to that of the inpatient margin.
- The overall Medicare margin peaked in 1997 at 11.5 percent. In fiscal year 2004, it was –3.0 percent.
- In 2004, one quarter of hospitals had overall Medicare margins of 5.5 percent or higher, and another quarter had overall margins of –14.5 percent or lower. Between 1997 and 2004, the difference in performance between the top and bottom quartile widened from 14 percent to 20 percent. About 39 percent of hospitals had positive overall Medicare margins in 2004, accounting for 34 percent of Medicare inpatient discharges.
- We estimate that the overall Medicare margin in 2006—reflecting 2007 payment policies other than updates—will be –2.2 percent.

Chart 7-14. Overall Medicare margins, by urban and rural location, 1997–2004

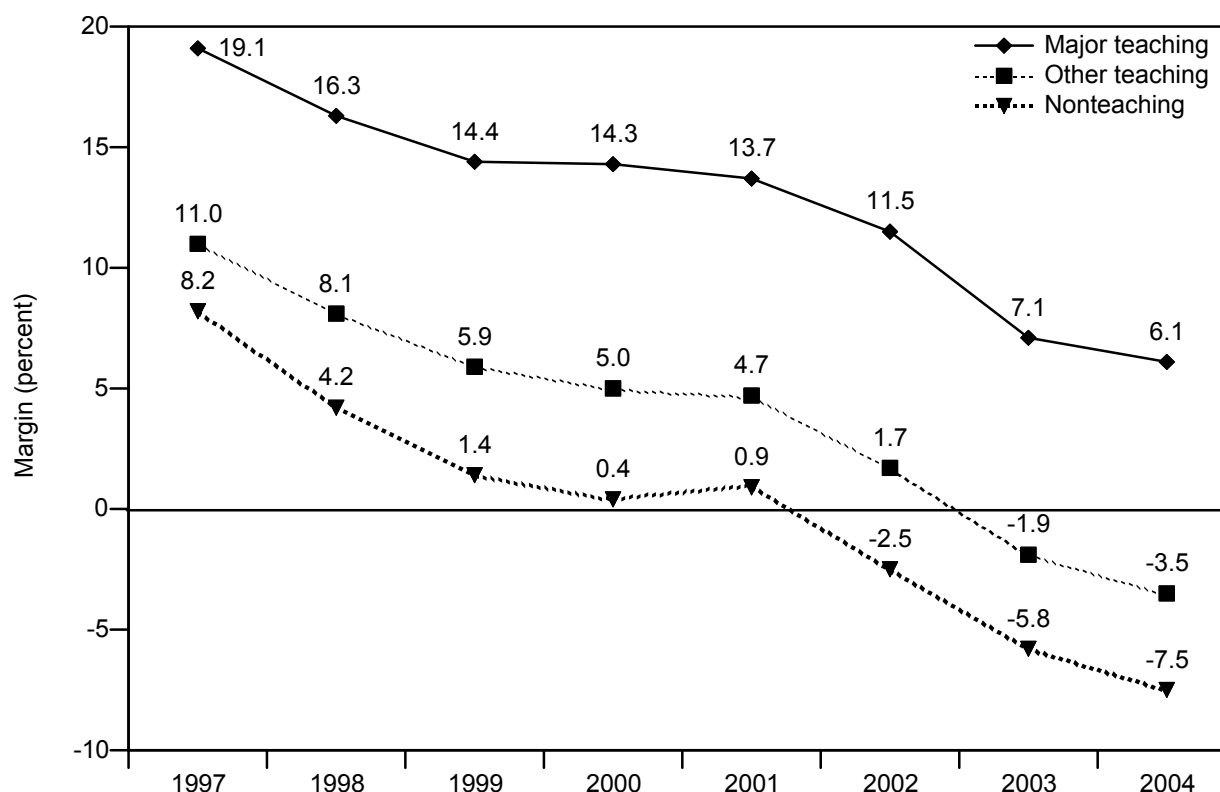


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- As with inpatient margins, overall Medicare margins have been consistently higher for urban hospitals than for rural hospitals.
- The difference in margins between the two groups grew between 1997 and 2000 but has since narrowed. In 1997, the overall margin for urban hospitals was 12.4 percent, compared with 6.0 percent for rural hospitals. In 2004, the overall margin for urban hospitals was –2.7 percent, compared with –4.6 percent for rural hospitals. Policy changes made in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 targeted to rural hospitals helped to narrow the difference in overall Medicare margins between urban and rural hospitals.
- A large part of the difference in financial performance between urban and rural hospitals is attributable to urban hospitals receiving more disproportionate share and indirect medical education payments.

Chart 7-15. Overall Medicare margins, by teaching status, 1997–2004

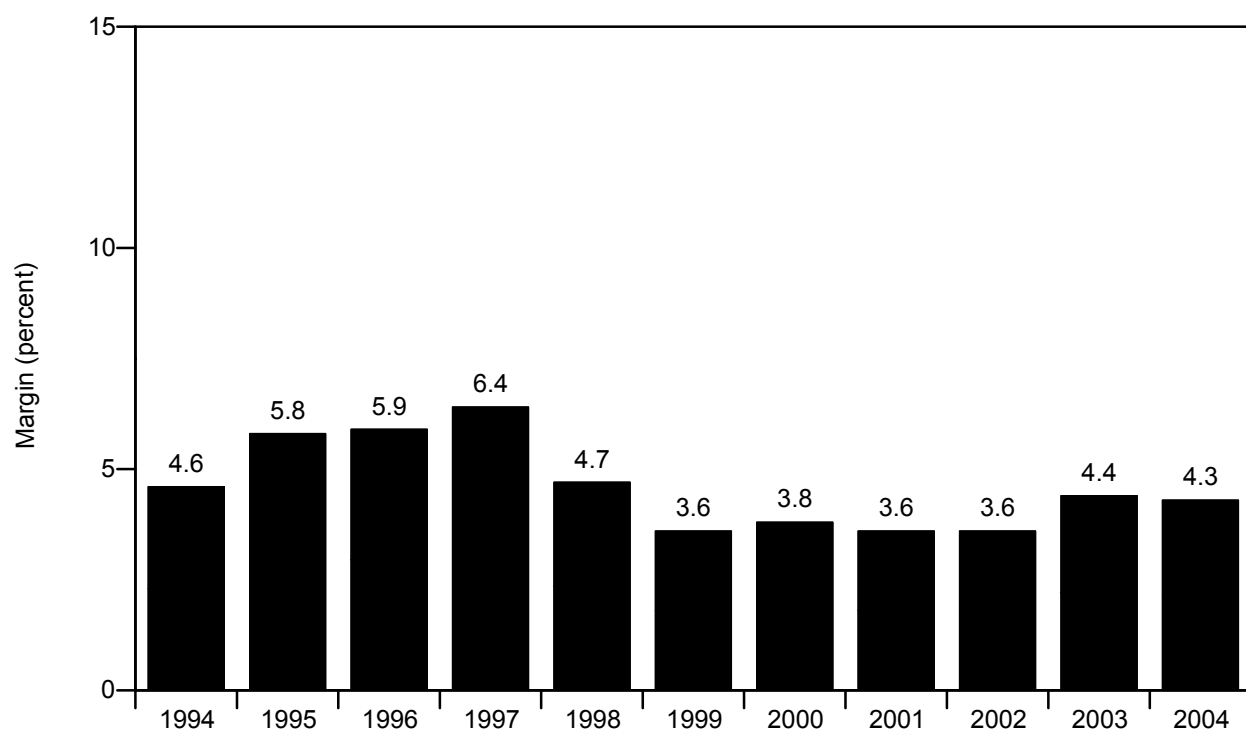


Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payment of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Data on overall Medicare margins before 1997 are unavailable.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Major teaching hospitals consistently have had higher overall Medicare margins than other teaching hospitals and nonteaching hospitals primarily because of the additional payments they receive through the indirect medical education and disproportionate share adjustments under the acute inpatient payment system.
- In 2004, overall Medicare margins for major teaching hospitals were 6.1 percent, compared with -3.5 percent for other teaching and -7.5 percent for nonteaching hospitals.
- The difference in overall Medicare margins between major teaching hospitals and nonteaching hospitals grew from about 11 percentage points in 1997 to 14 percentage points in 2000, reflecting in part the lower cost growth of major teaching hospitals.

Chart 7-16. Hospital total margin, 1994–2004

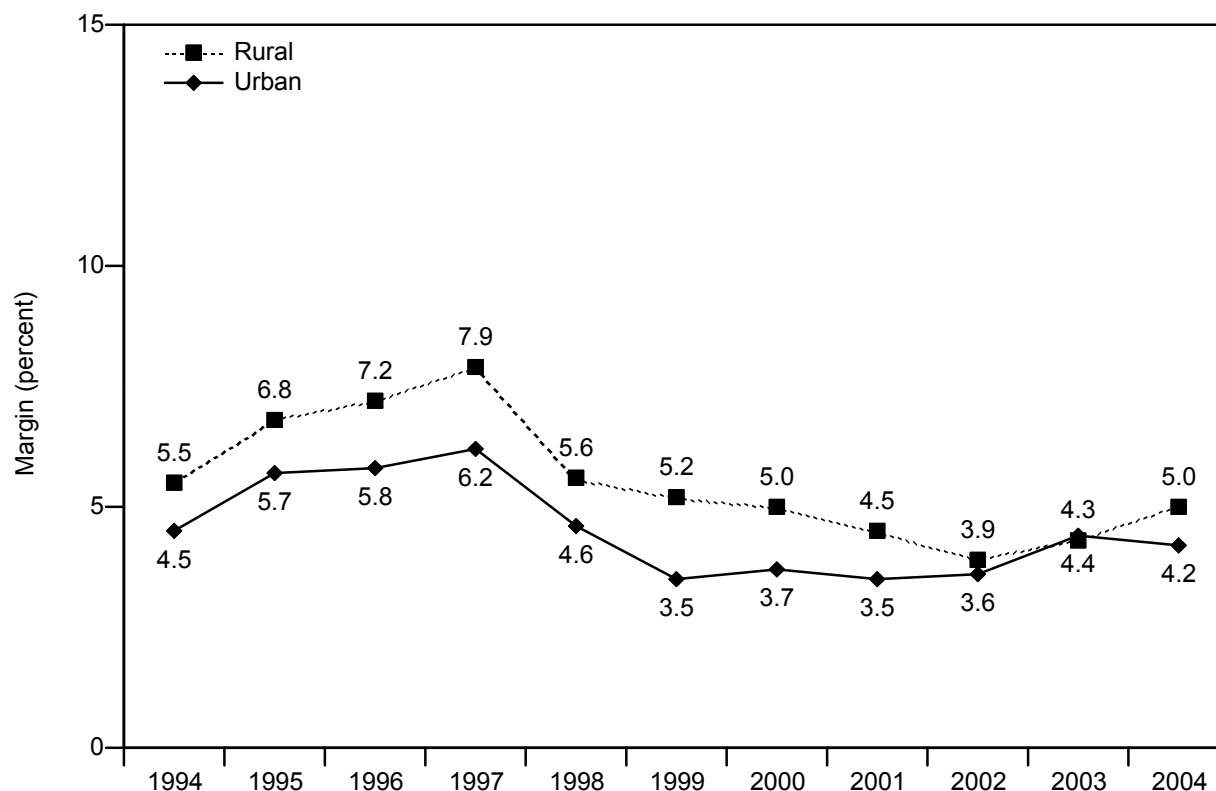


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- The total hospital margin for all payers—Medicare, Medicaid, other government and private payers—reflects the relationship of all hospital revenues to all hospital costs, including inpatient, outpatient, post-acute, and nonpatient services.
- The total hospital margin gradually climbed from 4.6 percent in 1994 to 6.4 percent in 1997, before declining to between 3.6 percent and 3.8 percent in the 1999 to 2002 period. In 2003, the total hospital margin climbed to 4.4 percent, its highest level in five years.
- The fall in total margins from 1997 to 1999 reflected a drop in both Medicare and private payer margins. Medicare overall margins from 1997 through 2001 were higher than the total margin.
- In 2004, 72 percent of hospitals had positive total margins. These hospitals accounted for 66 percent of all hospital discharges and 68 percent of Medicare discharges.
- The total margin varies much less than the Medicare inpatient or overall Medicare margin. In 2004, one quarter of PPS hospitals had total margins that were 7.3 percent or higher, while another quarter had margins that were –0.7 percent or lower, a spread of just 8 percentage points, compared to a 20 percentage point spread for overall Medicare margins and a 25 percentage point spread for Medicare inpatient margins.

Chart 7-17. Total hospital margin, by urban and rural location, 1994–2004

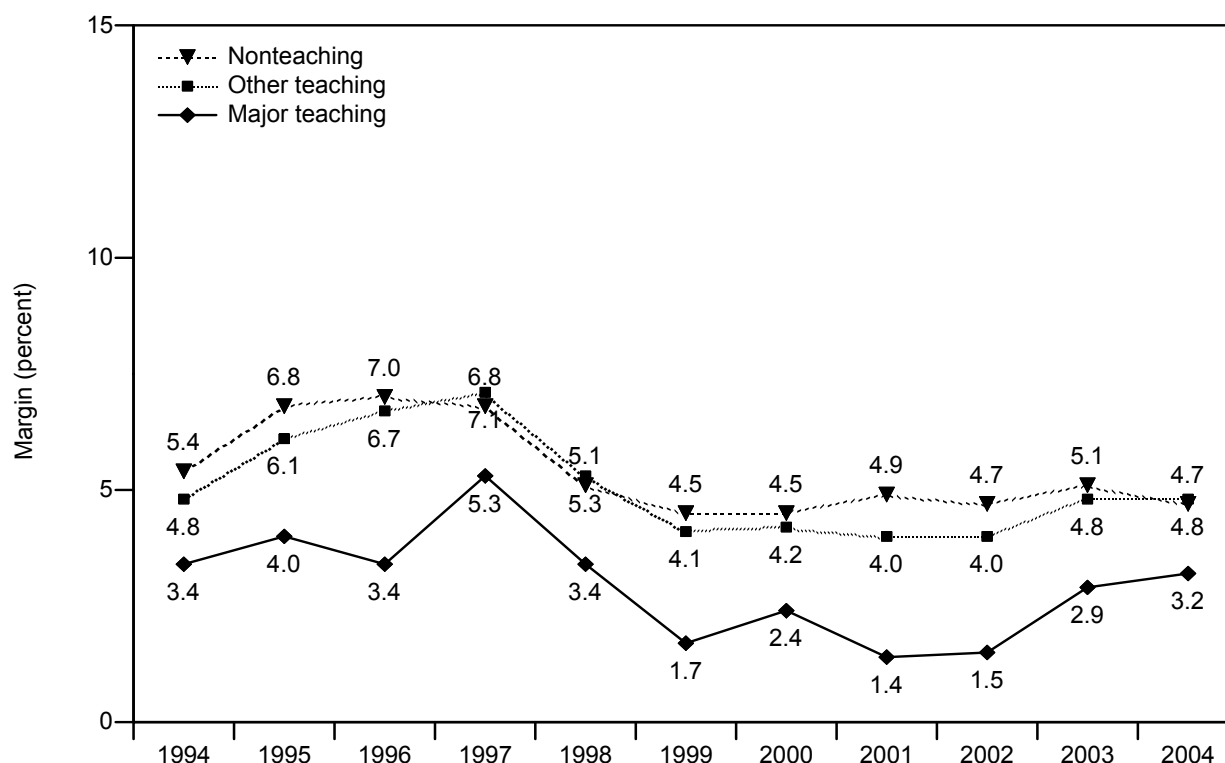


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- Until 2002, total margins for rural hospitals were consistently about 1 percentage point higher than total margins for urban hospitals.
- In 2004, total margins for rural hospitals were 5.0 percent, and for urban hospitals they were 4.2 percent.

Chart 7-18. Total hospital margin, by teaching status, 1994–2004



Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- The pattern of total margins by teaching status is the opposite of the pattern for the Medicare inpatient and overall Medicare margins. The total margins of major teaching hospitals have consistently been lower than those for other teaching and nonteaching hospitals. In 2004, the total margin for nonteaching hospitals stood at 4.7 percent compared with 3.2 percent for major teaching hospitals.
- The difference in margins between major teaching and nonteaching hospitals narrowed to only 1.5 percentage points in 2004, the smallest difference in over a decade.

Chart 7-19. Hospitals with consistently negative overall Medicare margins tend to have above-average costs

Hospital characteristic	Negative Medicare margin hospitals	Positive Medicare margin hospitals	All hospitals
Hospitals in group	986	828	2,923
(Share of total)	34%	28%	100%
Occupancy rate	52	58	55
Annual change in length of stay (1994–2004)			
Medicare	–2.4	–2.9	–2.6
All payers	–1.2	–1.5	–1.3
Standardized Medicare costs per discharge*	\$5,428	\$4,578	\$5,053
Annual change in Medicare costs per discharge (2001–2004)*	6.6%	5.6%	6.4%

Note: Values shown are medians for all hospitals with positive or negative margins for four consecutive years, 2001–2004. Data are for 2004 unless otherwise noted.

*Standardized for differences in case mix and severity of illness (using all patient refined diagnosis related groups), outlier cases, wage index, teaching intensity, and disproportionate share of low-income patients.

Source: MedPAC analysis of impact file, MedPAR, and Medicare Cost Report files from CMS.

- Between 2001 and 2004, about 34 percent of hospitals had consistently negative overall Medicare margins while 28 percent had consistently positive overall Medicare margins.
- About 3 percent of hospitals had consistently negative Medicare and consistently negative total (all payer) margins.
- Hospitals with consistently negative margins tended to have lower occupancy rates (52 percent) and smaller declines in length of stay (–2.4 percent). The lower occupancy rates should translate into higher unit costs because fixed costs are spread over fewer units of output.
- Medicare standardized costs per discharge were substantially above average for the negative margin hospital group (\$5,428) and substantially below average for the positive margin group (\$4,578).
- Medicare costs per discharge increased more slowly in positive margin hospitals than in negative margin hospitals over the four years analyzed, contributing to a widening gap in performance.

Chart 7-20. Hospitals with consistently negative overall Medicare margins have a poor competitive position in their market areas

Variable	Occupancy rate 2004	Cost per discharge 2004*
Hospitals with consistently negative Medicare and total margins	44%	\$5,276
Competitors within 15 miles	60	5,099
Hospitals with consistently negative Medicare margins only	52	5,428
Competitors within 15 miles	59	5,220
Hospitals with consistently positive Medicare margins	58	4,578
Competitors with 15 miles	60	4,908

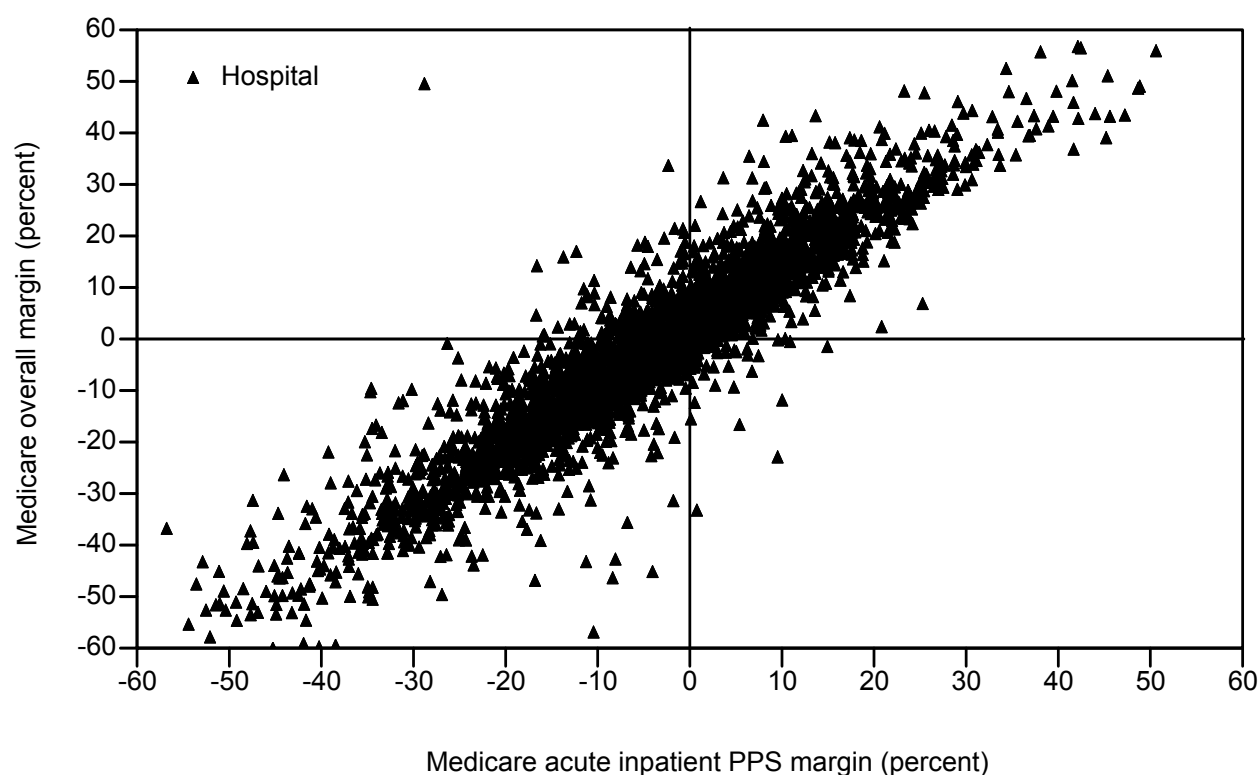
Note: Hospitals with mixed performance are excluded from this table. Values shown are medians for all hospitals with consistently positive or negative margins for four consecutive years, 2001–2004.

*Costs per discharge are Medicare costs, standardized for differences in case mix and severity of illness (using all patient refined diagnosis related groups), outlier cases, wage index, teaching intensity, and disproportionate share of low-income patients.

Source: MedPAC analysis of impact file, MedPAR, and Medicare cost report data from CMS.

- Hospitals with consistently negative overall Medicare margins from 2001 through 2004 had poorer competitive positions in their market, with lower occupancy rates and higher costs per discharge than competitors within 15 miles.
- Hospitals with both negative overall Medicare margins and negative total margins had even lower occupancy rates (44 percent) than those with negative Medicare margins alone (52 percent). These hospitals only account for about 3 percent of providers.
- Hospitals with consistently positive margins had close to the same occupancy rate but lower costs than their neighboring facilities.

Chart 7-21. Relationship of acute inpatient PPS and overall Medicare margins, 2004

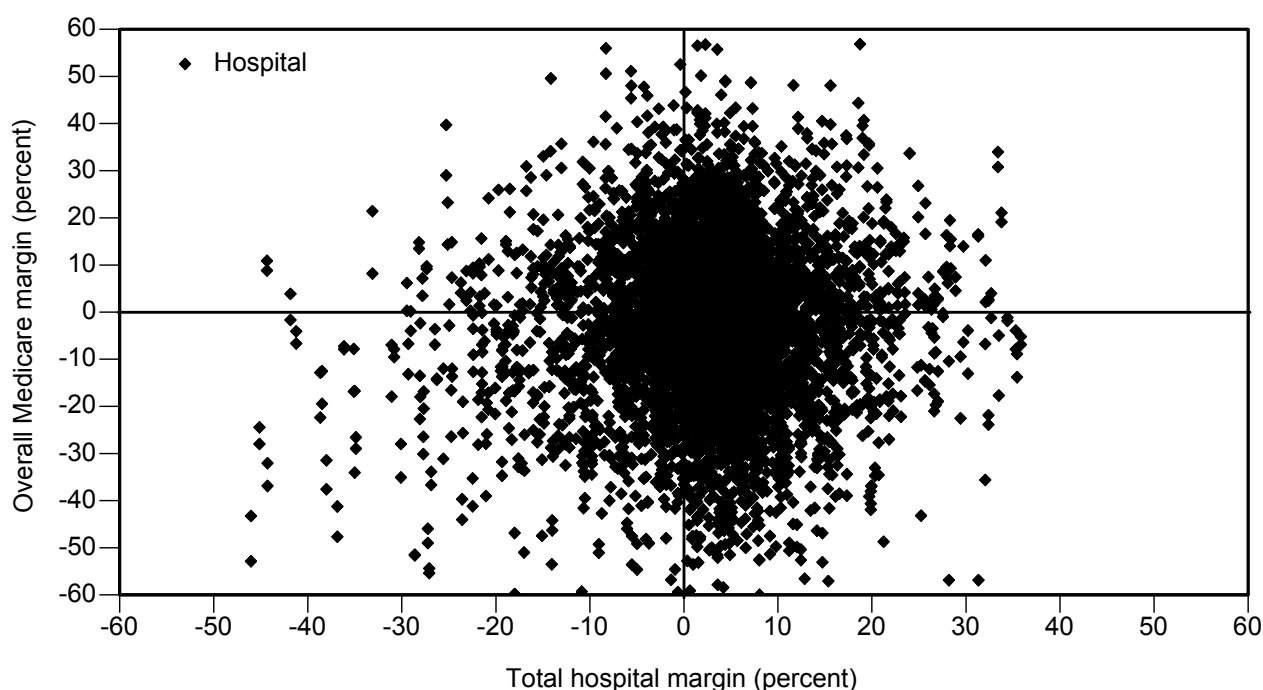


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. The Medicare acute inpatient PPS margin includes services covered by the acute care inpatient PPS. Overall Medicare margins cover the costs and payments of acute inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facilities, and home health services, as well as graduate medical education and bad debts.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- The Medicare inpatient and overall margins are strongly correlated ($R^2=0.776$). The Medicare overall and inpatient PPS margins are closely related in part because inpatient payments make up about three-quarters of total Medicare payments.
- The Medicare overall margin tends to be lower than the inpatient margin, which may be overstated due to cost allocation bias.

Chart 7-22. Relationship of overall Medicare and total margins, 2004



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2000 cost reports were not available. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of acute inpatient, outpatient, inpatient psychiatric and rehabilitation units, skilled nursing facility, and home health services, as well as graduate medical education and bad debts. Total margin includes all patient care services funded by all payers, plus nonpatient revenues.

Source: MedPAC analysis of Medicare cost report data (August 2005) from CMS.

- There is little relationship between hospitals' overall Medicare margins and total (all payer) margins ($R^2=0.006$). That is, hospitals' performance in Medicare is not a good predictor of their performance across all payers and vice versa.
- Hospitals with negative Medicare margins and those with positive Medicare margins were almost equally likely to have positive total margins: 73 percent of hospitals with negative overall Medicare margins had positive total margins, while 71 percent of hospitals with positive Medicare margins had positive total margins.
- Hospitals in the upper right quadrant of the graph (28 percent) had positive overall Medicare margins and positive total margins in 2004, whereas hospitals in the lower left quadrant (17 percent) had negative overall Medicare margins and negative total margins.

Chart 7-23. Consistently high-cost hospitals have Medicare margins that are far below average

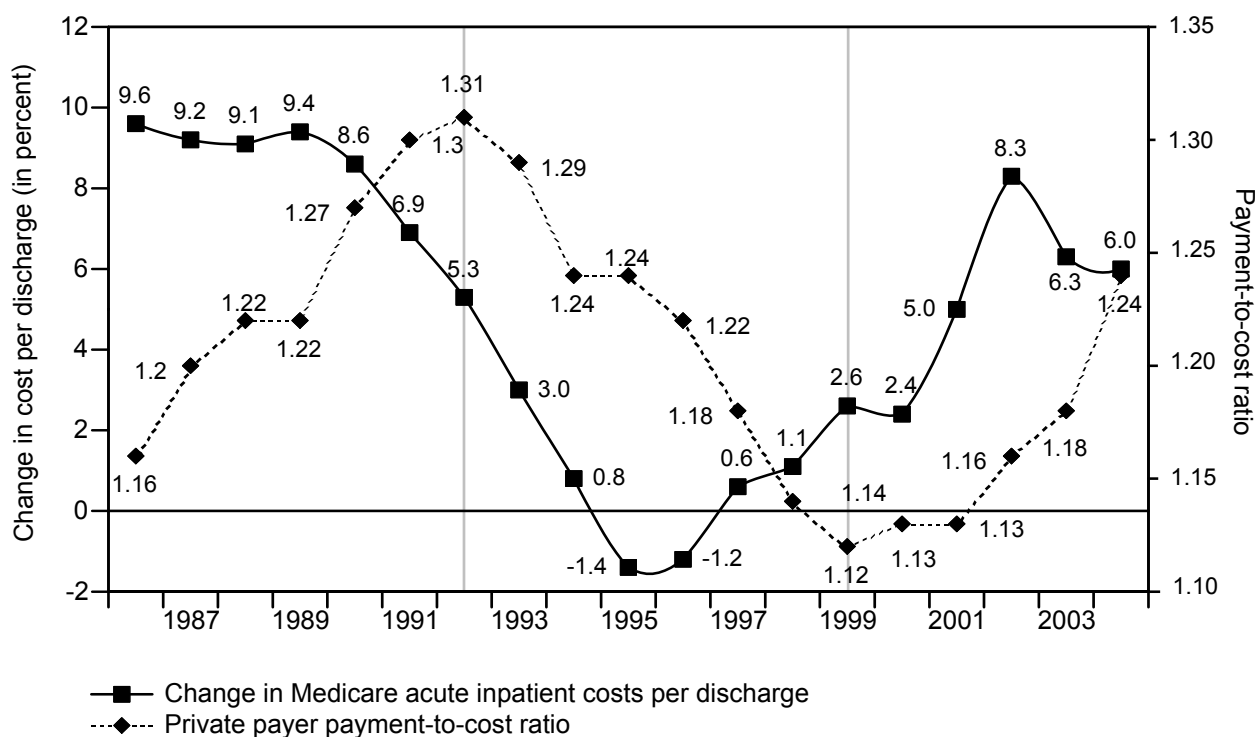
	Percent of hospitals	2002 to 2004 annual cost growth	2004 overall Medicare margin
Hospitals with consistently high costs	14%	6.6%	–16.6%
All hospitals	100	6.1	–3.0
Hospitals with consistently low costs	15	5.7	12.3

Note: Analysis includes all hospitals covered by Medicare's acute inpatient prospective payment system (PPS). Hospitals with consistently high or low costs are defined as in the highest or lowest quarter of all hospitals (ranked by standardized Medicare costs per discharge) in both 2002 and 2004. Costs were standardized for differences in case mix and patient severity (using all patient refined diagnosis related groups), outlier cases, wage index, teaching intensity, and disproportionate share of low-income patients.

Source: MedPAC analysis of impact file, MedPAR, and Medicare Cost Report data from CMS.

- About 14 percent of the hospitals covered by the acute inpatient prospective payment system (PPS) had consistently high costs, defined as being in the top quarter of all hospitals on a measure of standardized costs per case in both 2002 and 2004. About 15 percent of hospitals had consistently low costs, defined as being in the bottom quarter of all hospitals on the same measure in 2002 and 2004.
- Hospitals with consistently high costs have a substantial impact on the industry's financial performance under Medicare. These hospitals had an aggregate overall Medicare margin of –16.6 percent of 2004, substantially below the industry-wide figure of –3.0 percent. Consistently low-cost hospitals, in contrast, had a 12.3 percent margin.

Chart 7-24. Change in Medicare hospital inpatient costs per discharge and private payer payment-to-cost ratio, 1986–2004

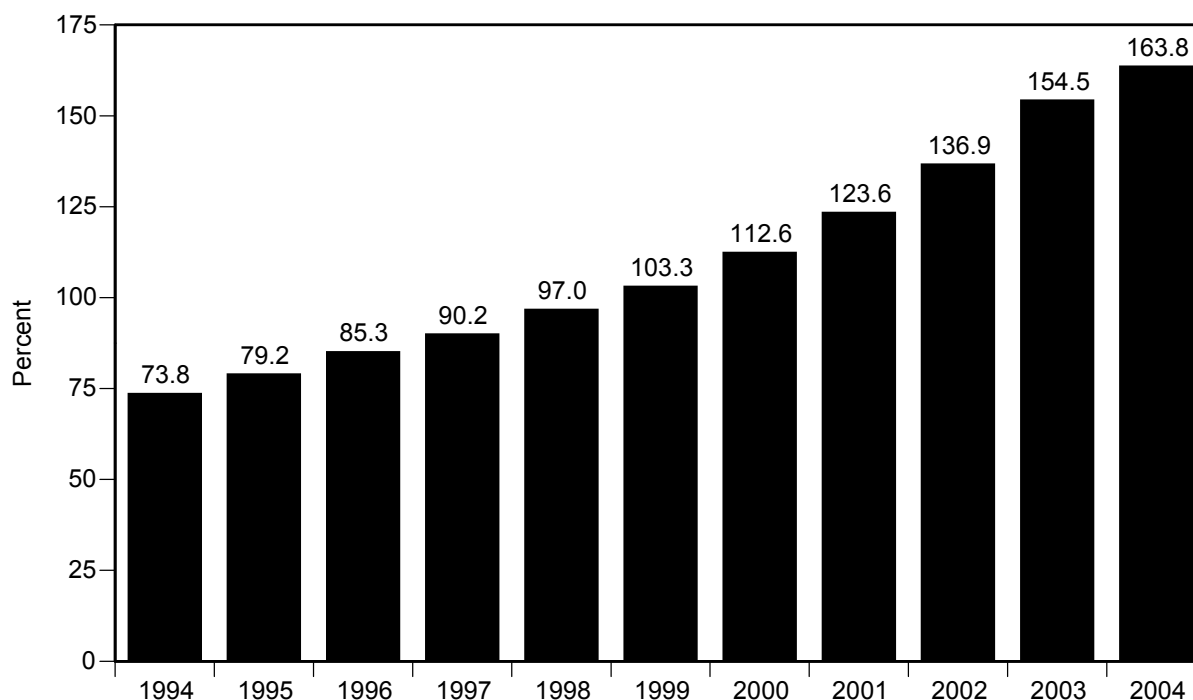


Note: Data are for community hospitals and cover all hospital services. Imputed values were used for missing data (about one third of observations). Most Medicare and Medicaid managed care patients are included in this private insurer category.

Source: MedPAC analysis of Medicare Cost Report file from CMS and CMS's rules for the acute inpatient prospective payment system, and American Hospital Association Annual Survey of Hospitals.

- The pattern of growth in Medicare costs per discharge makes it clear that hospitals have responded strongly to the incentives posed by the rise and fall of financial pressure from private payers over three periods.
- During the first period, 1986 through 1992, private payers' payments rose much faster than the cost of treating their patients (seen in the chart as a steep increase in the payment-to-cost ratio). This suggests an almost complete lack of pressure from private payers. Medicare costs per discharge rose 8.3 percent per year through these years, more than 3 percentage points a year above the increase in Medicare's market basket index.
- As HMOs and other private insurers exerted more pressure during the second period, 1993 through 1999, the private payer payment-to-cost ratio dropped substantially. The rate of cost growth plummeted to only 0.8 percent, which was more than 2 percentage points a year below the increase in the market basket.
- As pressure from private payers waned after 1999, the private payer payment-to-cost ratio has again risen sharply, and hospital cost growth has once again exceeded growth in the market basket by 2 percentage points a year.

Chart 7-25. Markup of charges over costs for all patient care services, 1994–2004

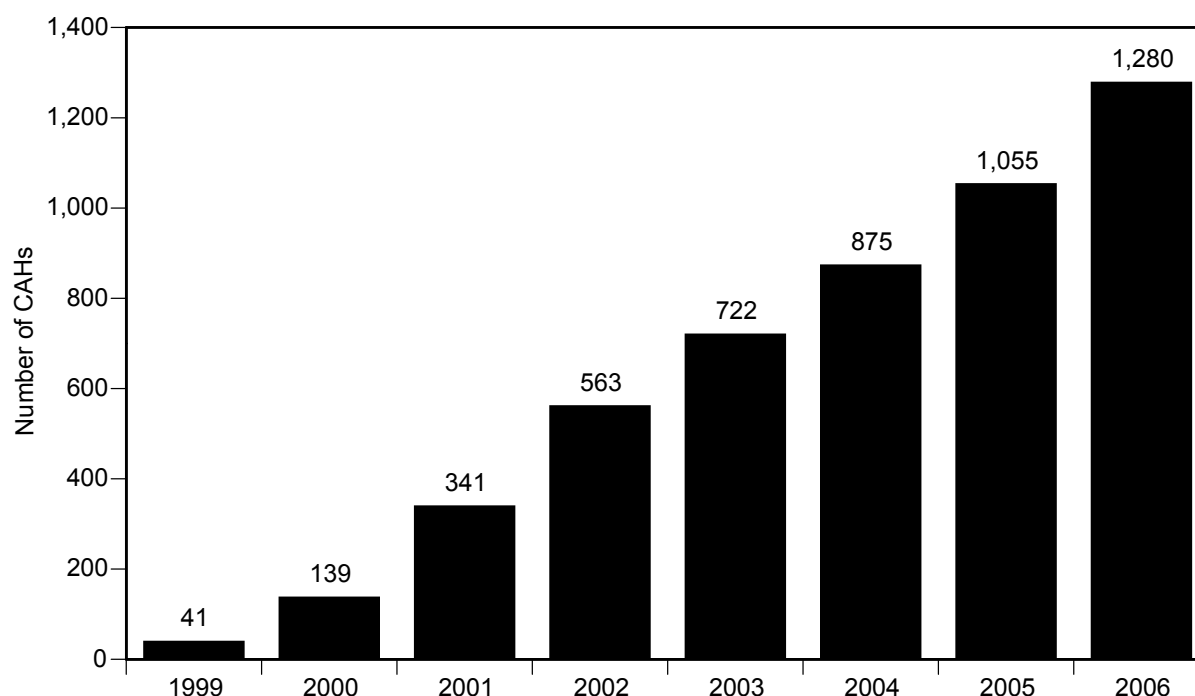


Note: Analysis includes all community hospitals.

Source: American Hospital Association Annual Survey of Hospitals.

- From 1994 through 2004, hospitals' patient care costs (covering all services and all payers) increased 5.8 percent per year but their charges went up by 10.3 percent per year, nearly twice as much. Consequently, the markup of charges over costs rose from 74 percent in 1994 to 164 percent in 2004. Charges are now more than two and a half times costs. In 2002 and 2003, the growth in markup—about 15 percentage points per year—was the largest since Medicare's acute inpatient PPS was implemented. The markup grew by 9 percentage points in 2004.
- Since few patients pay full charges, hospitals' increasing their charges more than their costs may not have had much impact on their financial performance. Some are concerned, however, that uninsured individuals may be asked to pay full charges and may have collection proceedings applied against them. Faster growth rates for charges in recent years may have resulted from hospitals' attempting to maximize revenue from private payers (who often structure their payments as a discount off charges) or their revenue from Medicare outlier payments. In 2003, Medicare revised its outlier policy in an attempt to curb hospitals' opportunity to increase their outlier payments through excessive increases in their charges.

Chart 7-26. Number of critical access hospitals, 1999–2006

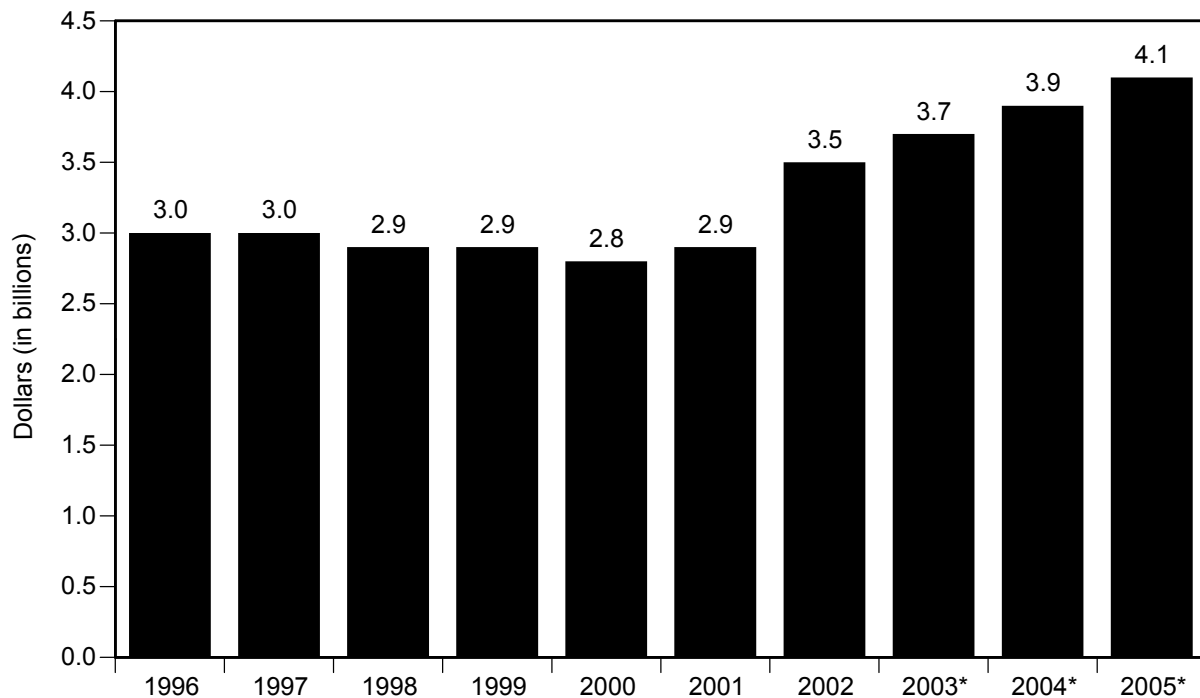


Note: Numbers of critical access hospitals are as of January 1 of each year.

Source: *The Rural Hospital Flexibility Tracking Project*. Third-Year Findings, February 2003, and additional data from CMS.

- The increase in critical access hospitals (CAHs) is in part due to a series of legislative changes that made conversion to CAH status easier and expanded the services that qualify for cost-based reimbursement. Currently, CAHs receive cost-based Medicare reimbursement for inpatient services, outpatient services (including laboratory and therapy services), and post-acute services in swing beds.
- The number of CAHs has grown steadily over the last seven years, from 41 in 1999 to 1,280 at the beginning of 2006.
- Prior to 2006, hospitals could convert to CAH status if they were either (a) 35 miles by primary road from the nearest hospital or 15 miles by secondary road from the nearest hospital or (b) their state waived the distance requirement by declaring the hospital a “necessary provider.” Starting in 2006, states can no longer waive the distance requirement. While most existing CAHs fail the distance test, they are grandfathered into the program. Among small rural PPS hospitals that have not converted, most would not meet the distance requirement. Therefore, we expect the number of CAHs to remain fairly constant at between 1,275 and 1,300 into 2007.

Chart 7-27. Medicare payments to inpatient psychiatric facilities, 1996–2005



Note: *Estimated spending.

Source: CMS, Office of the Actuary.

- Medicare program spending for beneficiaries' care in inpatient psychiatric facilities was relatively stable from 1996 to 2001. Between 2002 and 2005, however, CMS estimates that program spending will increase 9 percent per year, rising to 4.1 billion dollars.
- Spending on inpatient psychiatric facilities makes up about 1 percent of Medicare's total spending.
- The inpatient psychiatric facility payment system started January 1, 2005.

Chart 7-28. Inpatient psychiatric facilities, 1996–2005

	1996	1998	2000	2002	2004	2005
Freestanding hospitals	642	627	582	503	478	470
Hospital-based units	1,445	1,489	1,487	1,437	1,389	1,328
Total	2,087	2,116	2,069	1,940	1,867	1,798

Source: Online Survey, Certification, and Reporting system from CMS.

- Inpatient psychiatric facilities—both freestanding and hospital-based facilities—provide acute hospital care to beneficiaries with mental illnesses or alcohol- and drug-related problems.
- From 1996 to 2005, the number of Medicare-certified freestanding inpatient psychiatric facilities decreased by 27 percent while the number of hospital-based units decreased by 8 percent, with a total loss of 14 percent of psychiatric facilities. In 2005, there are 1,798 inpatient psychiatric facilities—470 freestanding and 1,328 hospital-based units.

Web links. Acute inpatient services

Short-term hospitals

- Chapter 2A of the MedPAC March 2006 Report to the Congress provides additional detailed information on hospital margins.

http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02a.pdf

- Chapter 2A of the MedPAC March 2002 Report to the Congress provides information on the hospital market basket.

http://www.medpac.gov/publications/congressional_reports/Mar02_Ch2A.pdf

- MedPAC provides basic information about the acute inpatient prospective payment system.

http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_hospital.pdf

- Additional information on the outlier payment issue can be found in the Medicare 2002 Hospital Outlier Payment Policy.

http://www.medpac.gov/publications/other_reports/outlier%20memo.pdf

- CMS provides information on the hospital market basket.

http://www.cms.hhs.gov/MedicareProgramRatesStats/04_MarketBasket.asp

- CMS published the proposed acute inpatient PPS rule in the April 25, 2006 *Federal Register*.

<http://www.gpoaccess.gov/>

Specialty psychiatric facilities

- CMS provides information on the inpatient psychiatric facility (IPF) prospective payment system.

<http://cms.hhs.gov/inpatientpsychfacilPPS/>

- CMS also provides information on the final rule for these facilities rate year 2007 starting July 1, 2006.

www.cms.hhs.gov/inpatientpsychiatricfacilPPS/downloads/CMS-1306-F5-01-06.pdf

